Mad in America
SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

Who Is Afraid of the Abolition of Psychiatric Confinement?

By **Mad in Greece** - July 11, 2024

Editor's Note: This blog originally appeared on Mad in Greece. The author, Alexis Krokidas, a member of Mad in Greece's editorial board, muses on the systems involved in keeping involuntary treatment a mainstay of psychiatry.

Compulsion continues to be a central pillar of psychiatry. It has two distinct but interrelated aspects. Firstly, the deprivation of liberty through the mechanism of involuntary hospitalization and, secondly, the forced—i.e. without the patient's full and informed consent—medication, electroconvulsive therapy (commonly electroshock) and other medical interventions including lobotomy (or leukotomy) which although relatively rare now, is still used.

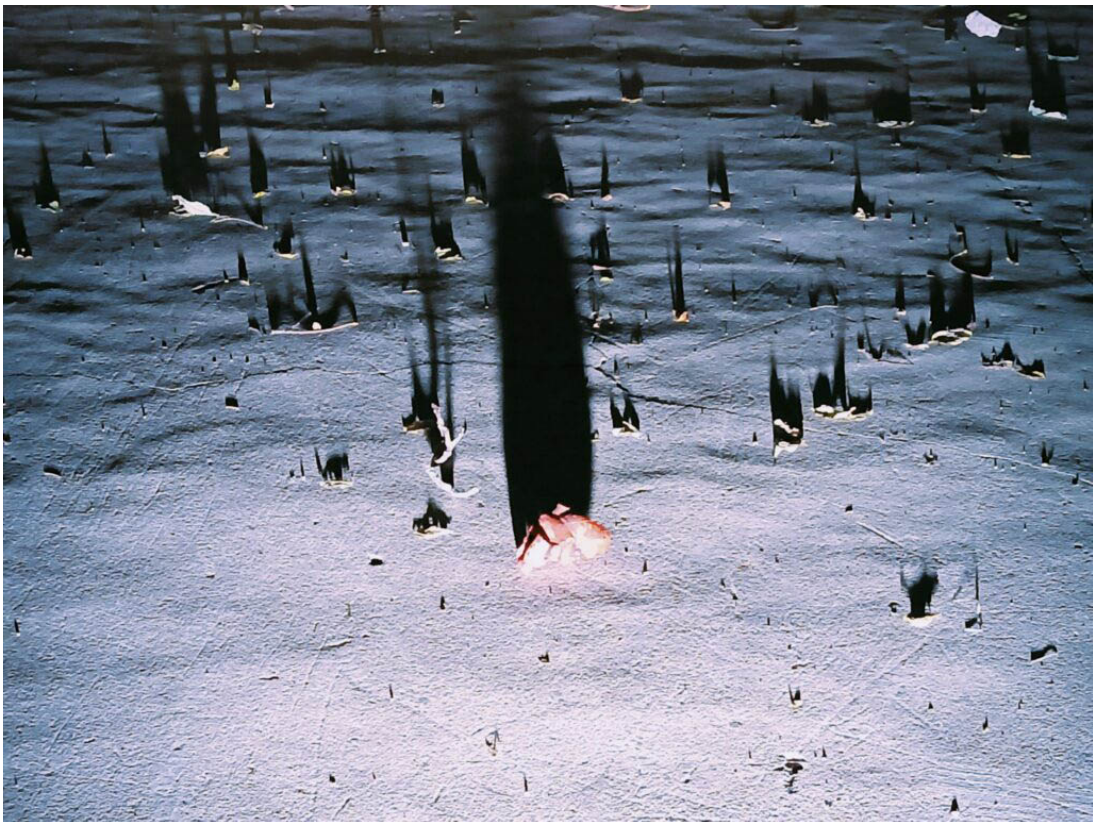

Photo: Worlds of milk. Agios Isidoros / PSNA "Dromokaiteio". From the project LARGACTIL directed by Katerina Kleitsiotis. A site-specific performance inspired by the texts of people with psychiatric experience and on the occasion of the work "Pure white" by the visual artist Konstantinas Karlis.

But why do we lock people up in psychiatric clinics against their will?

The usual answer is, for their own good and/or to protect others, or some combination/variation on the same theme. In all countries in the world where relevant legislation exists (not all do), the provisions governing how someone can be admitted to hospital against their will are more or less the same. The conditions or criteria are:

- To have a recognized mental disorder, i.e. a certified diagnosis.
- To be unable to judge in the interest of his health.
- For the good of his health, that is to say that there is a prediction that his condition is going to worsen, or his improvement is excluded, if he is not subjected to involuntary hospitalization and forced treatment.
- Risk criterion. Involuntary hospitalization is necessary to prevent acts of violence towards others, and/or to prevent suicide.

Of course, not all of the above are required and there are variations here and there, but basically, these are the criteria, the conditions for involuntary hospitalization. It should be noted here in passing that the so-called dangerousness criterion (provision for acts of violence) was implicitly abolished by the Treaty of Oviedo (Article 7) signed in April 1997 and ratified here in Greece by Law 2619/1998 (Government Gazette A'132).

Nevertheless, in practice, risk assessment continues to be, in combination with other criteria, the most common criterion for involuntary confinement. It is also worth noting here that the very concept of dangerousness in psychiatric contexts is socially dangerous and scientifically unsubstantiated. Back in 2017, my very dear Fotini Tsalikoglou, writer and professor of psychology at Panteio at the time, wrote in the Editors' Journal about the concept and use of risk in psychiatry. I have nothing to add here to her excellent analysis. I only recommend to those who haven't read it, to do so. Indeed, as used in the Ψ space, this is an extremely dangerous concept.

The dangerous "crazy" moreover, has been proven by the majority of relevant researches to be much less dangerous than the non-"crazy" outside of Ψ space. Let's say Adonis Georgiadis (and of course his political bosses) is extremely dangerous for public health. Like the former transport minister K. Karamanlis (and his political bosses) he was criminally dangerous to the lives of the people who were on the train on February 28, 2023.

But let me return to the dystopian psychiatric field.

The UN Committee on the Rights of Persons with Disabilities (although I do not subscribe to the term disability for many reasons, which are not here to analyze here) in the Guidelines it formulated in Article 14 of the Convention on the Rights of Persons with Disabilities and adopted at its 14th session in September 2015, makes a clear reference to dangerousness, underlining that (nor) the criterion of dangerousness can justify involuntary confinement and thus the deprivation of their liberty. Article 14, the Commission confirms, does not allow any exception, nor the criterion of dangerousness, and calls on the member states that have signed the Convention to take the appropriate actions for the absolute

abolition, i.e. without any exception, of the detention/deprivation of liberty of individuals with a disability. For background, countries that have signed but not ratified the Convention include the US, Chad, Libya, Uzbekistan.

I also mention here, by way of example, Dainius Pūras (2014-2020) special rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health, as well as Juan E. Méndez (2010-16) United Nations special rapporteur on torture and any other cruel, inhuman or degrading treatment or punishment, have in their relevant reports emphatically called on all the member states that have signed the Convention to take immediate action for the absolute prohibition of involuntary hospitalization and any coercive medical intervention on persons with disabilities, including non-consensual psychosurgery, electroshock, psychotropic drugs such as neuroleptics, the use of restraint and seclusion in the short or long term.

Of course, it is not only the concept of risk that is problematic and dangerous. If one examines one by one the remaining criteria, diagnosis…, not being able to judge…, for the good of his health…, he will discover that they are all extremely problematic, scientifically unsubstantiated, ineffective and ultimately dangerous not only for the subject to the humiliation and brutality of coercion, but also to the long-suffering existence of social freedom itself. Freedom can never be just an individual affair.

Despite this, or perhaps precisely because of this, coercion, repression, control, rather than care and solidarity, continue to be the pillars on which the psychiatric firmament rests.

Why? After all, who fears the abolition of involuntary confinement and coercive “treatment”?

Let’s look briefly.

Psychiatrists, but also other mental health professionals, such as social workers, nurses and psychologists who stubbornly refuse to step away from the power that their roles give them. The institutional, supra-institutional and symbolic roles of mental health professionals are structured around a threat: either you will comply with your treatment or I will impose it. We don’t care that you haven’t committed a crime. The law gives us the right and the authority to deprive you of your freedom for as long as we deem necessary, and not only to deprive you of your freedom, but also to tie you up if we deem it necessary, to immobilize you, to pull down your pants and let’s give you an injection of zuclopenthixol so you can see the sky flywheel. For your own sake. So simple and so creepy.

The pharmaceutical industries. The size of the global market for so-called antipsychotics alone, a class of drugs that are used coercively primarily in involuntary confinements, is estimated at $18 billion in 2023, with a forecast to reach $37 billion by 2032. They know very well because they have calculated it down to the last dollar, that in the absence of coercion, the market will shrink dramatically.

The State. Psychiatry, and the entire Ψ industry, is one of the most effective mechanisms of compliance, terror, subjugation and repression. If the coercion part is removed, the state will lose a valuable and well-honed tool of terror politics. The church was for centuries the best ally of power. This role has now been taken over by psychiatry and it plays it very well. Let us recall, for example, that what the Italian state failed to do through justice, despite the persistent and “philanthropic” efforts it made for many years, that is to say, to eliminate the tender and devoted primary school teacher and anarchist

activist Francesco Mastrogiovanni, psychiatry succeeded by murdering him during four days of involuntary hospitalization, mechanical restraint for 82 hours, and chemical sedation in a psychiatric ward at the San Luca Clinic in the town of Vallo della Lucania, province of Salerno on August 4, 2009. The chilling video of the torture he suffered (from hospital cameras) is accessible online, after his family decided to make it public.

The families of the mentally ill. It is known and documented by research that the vast majority of involuntary hospitalizations in Greece are initiated by families, often desperate, who, having nowhere else to turn, turn to the prosecutor requesting a prosecutorial order for involuntary hospitalization. It is understandable that they fear the abolition of involuntary hospitalization when there is no effective and integrated network of support and care in the community based on consent and humanity. As painful as this may sound, let us not hesitate to say something that is now supported by a growing body of research, the way some families function in specific social contexts and adverse social conditions is, if not decisive, at least very important to the emergence of and sustaining mental anguish.

Even people who themselves have undergone the process of involuntary hospitalization and involuntary medication. Although almost all research has shown that people subjected to this barbaric process experience it as something humiliating, violent and traumatic, there are still those who fear the abolition of involuntary confinement. Perhaps because they cannot imagine alternative ways of dealing with mental suffering. Perhaps because the threat of terrorism can destroy the very imagination and fantasy of freedom. Maybe because they are convinced that coercion works.

The “average” citizen, i.e. the world in general. The paternalistic-medical ideology of “madness”, with all its basic components, that e.g. the madman is by definition incapable of making rational decisions, that he does not know his own interest and what is for his own good, that he is dangerous to himself and others, and that we must save him from his madness, “heal” even against his will, after all, as a madman he has no free will, it is so successful that it does not even appear as an ideology, but as an indisputable reality. How can people not be afraid?

Who do we really want to save?

About 7 million deaths a year are caused by smoking. Why don’t we lock up smokers against their will to save them?

About 4 million deaths a year are caused by alcohol use. Why don’t we lock up the drinkers to save them too?

About 1.5 million deaths in traffic accidents. Why don’t we oblige all drivers, without exception, to take a risk test, and those who are found to be dangerous we lock them into the car as a precaution for the protection of others?

Why, because they are sane and know the risks they are taking, while the crazy are crazy and don’t know the risks they are taking and we have to save them.

And what does salvation mean?

Happy resurrection and happy freedom.

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Mad in Greece

We are campaigning for a change in the professional, scientific and public discourse around emotional distress and 'unusual' experiences. For support, both in and out of services, that meets people's real needs; and for social policies that address the root causes of distress.